c. Outpatient facility.

d. Nursing home.

e. School.

6. The provider who performs psychotherapy must engage in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed under the medical assistance program.

7. Outpatient psychotherapy services for up to 15 hours or $500 per recipient in a 12-month period may be reimbursed without prior authorization. The 12-month period begins on the first date of the actual provision of psychotherapy services. If reimbursement is also made to any provider for alcoholism or other drug abuse treatment services outlined in section 7.13(1)(d) [(3)] during the same 12-month period for the same recipient, the hours reimbursed for such services will be considered a concurrent part of the amount available for psychotherapy. Likewise, if several psychotherapy providers are treating the same recipient during a 12-month period, all the psychotherapy shall be considered in the $500 or 15 hour total. If a recipient is hospitalized as an inpatient in an acute care general hospital with a diagnosis of, or for a procedure associated with, a psychiatric condition, reimbursement for any inpatient psychotherapy services will not be considered a concurrent part of the amount available for outpatient psychotherapy. The differential diagnostic examination for psychotherapy and the medical evaluation for alcoholism or other drug abuse treatment services shall also be covered as additional items.

(b) *Services Requiring Prior Authorization—Outpatient psychotherapy services.*

1. Reimbursement beyond 15 hours or $500 of service may be claimed for treatment services furnished after receipt of authorization by the department. Services reimbursed by any third party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified number of hours of outpatient services to be provided to a recipient within the 12 month period.

3. The department shall set limits on the number of hours for which prior authorization is approved. The department shall require periodic progress reports and subsequent prior authorization requests in instances where additional services are requested.

4. Persons who review prior authorization requests for the department shall have the same minimum training required of providers.

5. The prior authorization request shall include the following information:

a. The name, address and medical assistance provider or identifier numbers of the providers conducting the diagnostic examination or medical evaluation and performing psychotherapy or performing AODA services.

b. The physician's original prescription for treatment.

c. When authorization is being requested for psychotherapy services, a detailed summary of the differential diagnostic examination, setting forth the severity of the mental illness of medically significant emotional or social dysfunction and the medical necessity for psychotherapy and the expected outcome of treatment.

d. A copy of the treatment plan which shall relate to the findings of the diagnostic examination or medical evaluation and specify behavior and personality changes being sought.

e. A statement of the estimated frequency of treatment sessions, the estimated cost of treatment and the anticipated location of treatment.

6. The provider requesting prior authorization shall be notified in writing of the department's decision. In cases of a denial of the request, the recipient will also be notified in writing of the department's decision.

(c) *Other Limitations—Outpatient psychotherapy services.*

1. Collateral interviews are limited to members of the recipient's immediate family; parents, spouse or children, or for children in foster care, foster parents.

2. Group sessions. A psychotherapy group session means a session at which there are more than one but not more than 10 recipients receiving psychotherapy services together from one or two providers.

3. Emergency psychotherapy. Emergency psychotherapy may be performed by a provider for a recipient without a prescription for treatment or prior authorization when the provider has reason to believe that the recipient may immediately injure himself or herself or any other person. A prescription for the emergency treatment must be obtained within 48 hours of the time the emergency treatment was provided excluding weekends and holidays. Reimbursement for emergency psychotherapy may be made in accordance with HSS 105.22 (3). Subsequent treatment may be provided if HSS 107.13 (1) (c) [(2)] is followed.

4. Not more than one provider shall be reimbursed for the same treatment session, unless the session involves a couple, a family group or is a group session as described in HSS 107.13 (3) (b) (2) [(2) (c) 2.]. Under no circumstances shall more than 2 providers be reimbursed for the same session.

(d) *Non-Covered Services—Outpatient psychotherapy services.*

1. Collateral interviews with persons not stipulated in HSS 107.12 (2) (c) and consultations are not covered services.

2. Court appearances or evaluations, except as noted in HSS 107.03 (10) are not covered services.

3. Psychotherapy is not a covered service for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention.

4. Psychotherapy provided in a person's home.

5. Self-referrals are not covered. For purposes of this section, a self-referral means a provider referring a recipient to an agency in which the

provider has a direct financial interest, or to himself or herself acting as a practitioner in private practice.

(3) ALCOHOL AND OTHER DRUG ABUSE SERVICES.

(a) Outpatient alcohol and drug abuse treatment services are covered when prescribed by a physician and when provided by a provider who meet the requirements of HSS 105.23, and when the following conditions are met:

1. The treatment services furnished are in accordance with the definition in chapter one of this rule.

2. Before the enrollment in an alcohol or drug abuse treatment program, the recipient shall receive a complete medical evaluation. The evaluation shall include diagnosis, summary of present medical findings, medical history, and explicit recommendations by the physician for participation in the alcohol or other drug abuse treatment program. A medical evaluation performed for such purpose within 60 days prior to enrollment shall be valid for reenrollment.

3. The supervising physician or psychologist shall be responsible for development of a treatment plan, which shall relate to behavior and personality changes being sought, and to the expected outcome of treatment.

4. Outpatient alcohol or other drug abuse treatment services for up to $500 or 15 hours in a 12-month period may be reimbursed without prior authorization. The medical evaluation shall be covered as an additional item.

(b) *Services Requiring Prior Authorization—Outpatient Alcohol or Other Drug Abuse Treatment Services.*

1. Reimbursement beyond 15 hours or $500 of service may be claimed for treatment services furnished after receipt of authorization by the department. Services reimbursed by any third party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified number of hours of outpatient services to be provided to a recipient within the 12 month period.

3. The department shall set limits on the number of hours for which prior authorization is approved. The department shall require periodic progress reports and subsequent prior authorization requests in instances where additional services are requested.

4. Persons who review prior authorization requests for the department shall have the same minimum training required of providers.

5. The prior authorization request shall include the following information:

a. The name, address and medical assistance provider or identifier numbers of the providers conducting the medical evaluation and performing AODA services.

b. The physician's original prescription for treatment.

c. A copy of the treatment plan which shall relate to the findings of the medical evaluation and specify behavior and personality changes being sought.

d. A statement of the estimated frequency of treatment sessions, the estimated cost of treatment and the anticipated location of treatment.

6. The provider requesting prior authorization shall be notified in writing of the department's decision. In cases of a denial of the request, the recipient will also be notified in writing of the department's decision.

(c) *Non-Covered Services—Alcoholism/Drug Abuse Treatment.*

1. Court appearances or evaluations, except as noted in HSS 107.03 (10) are not covered services.

2. Collateral interviews and consultations are not covered services.

(4) DAY TREATMENT OR DAY HOSPITAL SERVICE. *Covered services.*

(a) Day treatment or day hospital services are covered services when prescribed by a physician and when provided by a provider who meets the requirements of HSS 105.245, and when the following conditions are met:

1. The day treatment services are furnished in accordance with the definition of day treatment in chapter one of this rule.

2. Before the involvement in a day treatment program, the recipient shall undergo an evaluation through the use of the functional assessment scale provided by the department, to determine the medical necessity for day treatment and the person's ability to benefit from it.

3. The supervising psychiatrist shall approve a written treatment plan for each recipient and shall review such plan no less frequently than once every 60 days. The treatment plan shall be based on the initial evaluation and shall include individual goals and the treatment modalities to be used to achieve these goals, and the expected outcome of treatment.

4. Reimbursement may be made without prior authorization from the department for up to 120 hours of day treatment service in a 12-month period which begins on the first date day treatment services are provided. Psychotherapy services or occupational therapy services provided as component parts of a person's day treatment package shall not be billed separately, but shall be billed and reimbursed as part of the day treatment program.

5. Day treatment or day hospital services provided to recipients with inpatient status in a hospital shall be limited to 20 hours per inpatient admission, and shall only be available to patients scheduled for discharge, to prepare them for discharge.

6. Reimbursement shall not be made for day treatment services provided in excess of 30 hours of treatment in any week.

7. Day treatment services are covered only for the chronically mentally ill and acutely mentally ill who have a need for day treatment, and an ability to benefit from the service, as measured by the functional assessment scale authorized by the department.

8. Billing for day treatment services shall be submitted by the 51.42 board. Reimbursement shall be at 90% of the rate established by the department. Day treatment services shall be billed as such, and not as psychotherapy, occupational therapy or any other modality.

(b) *Services Requiring Prior Authorization—Day Treatment or Day Hospital Services.*

1. Prior authorization is required for day treatment services provided beyond 120 hours of service in a 12-month period.

2. Prior authorization is required for all day treatment or day hospital services provided to recipients with inpatient status in a nursing home. Only those patients scheduled for discharge are eligible for day treatment. No more than 40 hours of service will be authorized in a 12-month period.

a. The prior authorization request shall be requested by the provider and shall include:

i. The name, address, and medical assistance number of the recipient.

ii. The name, address, and provider number of the provider of the service and of the billing provider.

iii. The physician's original prescription for treatment.

iv. A copy of the treatment plan and the expected outcome of treatment.

v. A statement of the estimated additional dates of service necessary and total cost.

b. The provider requesting prior authorization and the recipient shall be notified in writing of the department's decision.

(c) *Non-Covered Services—Day Treatment or Day Hospital Services.*

1. Day treatment services which are primarily recreation-oriented and which are provided in a non-medically supervised setting such as 24-hour day camps, or other social service programs are not covered services.

2. Consultation with other providers or service agency staff regarding the care or progress of a recipient are not covered services.

3. Preventive or education programs provided as an outreach service; and/or casefinding are not covered services.

4. Aftercare programs, provided independently or operated by or under contract to community mental health agencies under 51.42 or 51.437 are not covered services.

5. Court appearances or evaluations, except as noted in HSS 107.03(10), are not covered services.

6. Day treatment is not covered for recipients with a primary diagnosis of mental retardation.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.14 Podiatry services. (1) COVERED SERVICES. Podiatry services covered by medical assistance include those medically necessary services for the diagnosis and treatment of the feet, within the limitations described below, when provided by a certified podiatrist.

(2) OTHER LIMITATIONS.

(a) Podiatric services pertaining to the cleaning, trimming, and cutting of toenails (often referred to as palliative or maintenance care, or debridement) will be reimbursed on a once per 31 day period if the recipient is under the active care of a physician, and when the recipient's condition is one of the following:

1. Diabetes mellitus;

2. Arteriosclerosis obliterans evidenced by claudication;

3. Peripheral neuropathies involving the feet, which are associated with:

a. malnutrition or vitamin deficiency;

b. carcinoma;

c. diabetes mellitus;

d. drugs and toxins;

e. multiple sclerosis;

f. uremia.

The cutting, cleaning, and trimming of toenails, corns, callouses, and bunions on multiple digits, will be reimbursed at one fee for each service which includes either one or both appendages.

(b) Initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring non-covered care.

(c) Physical medicine is a covered service but is limited to ultrasound and diathermy only for the following diagnoses:

1. symptomatic osteoarthritis.

2. tendonitis.

3. bursitis.

(d) On a podiatrist's claim for a nursing home visit (for the cutting, cleaning, trimming of toenails, corns, callouses, and bunions), the program will reimburse at the nursing home visit procedure code rate for only one of the patients seen on that day of service. All other claims for patients seen at the nursing home on the same day of service will be reimbursed up to the multiple nursing home visit rate. The podiatrist shall identify on the claim form the single patient for whom the nursing home single patient rate may be allowed, and the patient (s) for whom the multiple nursing home visit rate is applicable.

(e) For mulutiple surgical procedures performed on the same day the podiatrist will be reimbursed as follows:

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1. first procedure at 100%;

2. second procedure at 50%;

3. third procedure at 25%;

4. fourth procedure at 12.5%.

Additional surgical procedures performed on the same foot within 120 days of the original surgery will be paid at 50%. Post-operative care, office calls and dressings are considered part of the surgical fee.

(f) The administration of antibiotics is limited to LA, AP, or penicillin for the purpose of treating cellulitis or an acute "itis" associated with foot disease.

(g) Debridement of mycotic conditions and mycotic nails are a covered service per utilization guidelines established by the department of health and social services.

(h) The application of unna boots is allowed once per two weeks.

(3) NON-COVERED SERVICES. The following are non-covered services (in addition to HSS 107.03):

(a) Procedures which do not relate to the diagnosis or treatment of the ankle and foot are not covered.

(b) Palliative or maintenance care, except as enumerated in subsection (2) above.

(c) Orthopedic shoes and supportive devices such as arch supports, shoe inlays, and pads.

(d) Services directed toward the care and correction of "flat feet."

(e) Treatment of subluxation of the foot.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

6.c. **HSS 107.15 Chiropractic services.** (1) *Covered services.* Chiropractic services which are covered by the medical assistance program are manual manipulations of the spine used to treat a subluxation, and certain specific diagnostic services. Such services shall be performed by a chiropractor certified pursuant to section HSS 105.26.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [Note: For more information on prior authorization, see HSS 107.02(3).]

(a) Prior authorization is required for services beyond the initial visit and 28 manipulations during a 12 month period per recipient per episode of illness as defined in HSS 107.15 (3) (a). The prior authorization request must include a justification of why the condition is chronic and why it warrants the scope of service being requested.

(b) Spinal supports which have been prescribed by a physician or chiropractor are a covered service. If the purchase or rental price of the support is over $75.00, prior authorization is required. Rental costs under $75.00 will be paid for one month without prior approval.

(3) OTHER LIMITATIONS. (a) An x-ray or set of x-rays (such as anterior-posterior and lateral) is a covered service once per episode of illness — 1st under T19

if the x-ray(s) is performed either in the course of diagnosing a spinal subluxation or in the course of verifying symptoms of other medical conditions beyond the scope of chiropractic. (Episode of illness is defined as either the acute onset of a new condition or re-occurrence of a preexisting condition which limits the functional ability of the recipient and requires a sequence of chiropractic adjustments to rectify).

(b) A diagnostic laboratory test is a covered service for an initial office visit only; or when related to the diagnosis of a spinal subluxation; or when verifying a symptomatic condition beyond the scope of chiropractic. The only test covered is urinalysis, when used solely for assessing the possible existence of underlying medical conditions (i.e. diabetes, infections).

(c) The billing for an initial office visit must clearly describe all procedures performed to insure accurate reimbursement.

(4) NON-COVERED SERVICES. Consultations (second opinions) between providers regarding a diagnosis of treatment are not a covered service.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.16 Physical therapy. (1) *Covered services.* Covered physical therapy services are those medically necessary modalities, procedures and evaluations enumerated in this section, when performed by or under the supervision of a qualified physical therapist and when prescribed by a physician. Reimbursement for covered physical therapy services shall be based on the treatment unit(s) performed.

(a) *Evaluation.* Covered evaluations are those enumerated in the list below: (A written report of the results of the evaluation performed shall accompany the test chart or form in the recipient's medical record.)

1. Stress test;
2. Orthotic check-out;
3. Prosthetic check-out;
4. Functional evaluation;
5. Manual muscle test;
6. Isokinetic evaluation;
7. Range of motion measure;
8. Length measurement;
9. Electrical testing:

a. Nerve conduction velocity;

b. Strength duration curve—chronaxie;

c. Reaction of degeneration;

d. Jolly test (twitch tetanus);

e. "H" test;

f. Electro-myography;

required, or when 60 treatment days have been exhausted, whichever comes first.

(c) A spell of illness must be documented in the plan of care.

(d) Unused treatment days from one spell of illness shall not be carried over into a new spell of illness.

(e) With proper documentation, the department may approve prior authorization requests for up to a year of preventive/maintenance speech therapy.

(f) Treatment days covered by Medicare or other third-party insurance shall be included in computing the 60-day total.

(g) To the extent that the legislature appropriates sufficient funds and position authority, the department will have on its staff qualified speech therapist(s) to review prior authorization requests and perform other consultative activities.

(h) A peer review committee will serve to assist in review of claims and prior authorization requests, to advise the department and to act as first level of an appeal mechanism.

(3) OTHER LIMITATIONS. The limitations of HSS 107.16 (3) apply to speech pathology services.

(4) NON-COVERED SERVICES. (a) Services which are of questionable therapeutic value in a program of speech pathology shall not be covered. For example, charges by speech pathology providers for "language development—facial physical," "voice therapy—facial physical" or "appropriate outlets for reducing stress" shall not be covered.

(b) Activities not associated with the treatment of a recipient, such as the end of day clean up of the treatment area, shall not be reimbursable services.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.19 Audiology. (1) *Covered services.* Covered audiology services are those medically necessary diagnostic, screening, preventive or corrective audiology services prescribed by a physician and provided by or under the supervision of an audiologist certified pursuant to section HSS 105.31. Such services include:

(a) Audiological evaluation;

(b) Hearing aid evaluation;

(c) Hearing aid performance check;

(d) Audiological tests;

(e) Audiometric techniques;

(f) Impedance audiometry;

(g) Aural rehabilitation;

(h) Speech and audio therapy.

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(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [Note: For more information on prior authorization, see HSS 107.02 (3).] The following services require prior authorization from the department:

(a) Speech and audio therapy;

(b) Aural rehabiliation, including:

1. Use of residual hearing;

2. Speech reading or lip reading;

3. Compensation techniques;

4. Gestural communication techniques;

(c) Dispensing of hearing aids;

(d) Requests for prior authorization of audiological services shall be reviewed only if such requests contain the following information:

1. The number of treatment days requested;

2. The name, address and medical assistance number of the recipient;

3. The name of the provider of the requested service;

4. The name of the person or agency making the request;

5. The attending physician's diagnosis, indication of degree of impairment, and justification for the requested service;

6. An accurate cost estimate if the request is for the rental, purchase or repair of an item; and

7. If out-of-state non-emergency service is requested, a justification for obtaining service outside of Wisconsin, including an explanation of why service cannot be obtained in the state.

(3) OTHER LIMITATIONS. The limitations of HSS 107.16 (3) apply for audiology services.

(4) NON-COVERED SERVICES. See S. HSS 107.03 for services which are not covered services.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

12.d. **HSS 107.20 Vision care services.** (1) COVERED SERVICES. Covered vision care services are eyeglasses and those medically necessary services provided by licensed and certified optometrists within the scope of practice of the profession as defined in s. 449.01, Stats., and by physicians.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [Note: For more information on prior authorization, see HSS 107.02 (3).] The following services require prior authorization by the department:

(a) Visual training, orthoptics, and pleoptics;

(b) Aniseikonic services;

(c) Tinted eyeglass lenses except for tints number 1 or 2 of the rose type;